ORIGINAL

CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

May 22, 2014
10:00 A.M.
Room 125 Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Donald Neel
Sharon Branham
Susanne Watkins
Peggy Roark
Susie Riley
Richard Foley
COUNCIL MEMBERS PRESENT

CAPITAL CITY COURT REPORTING
TERRI H. PELOSI, COURT REPORTER
900 CHESTNUT DRIVE
FRANKFORT, KENTUCKY 40601
(502) 223-1118

AGENDA

CHAIR PARTIN: I'll call the meeting to order. First on the agenda, I would like to thank Sharley Hughes for the work that she's done staffing this committee. She has done an excellent job. She is on vacation this week, so, she can't be here, but I'd like to ask the committee to still give her a round of applause for the work that she's done.

And, then, I'd also like to welcome Barbara Epperson. We look forward to working with her, and so far, everything has gone flawlessly. So, thank you very much.

MS. EPPERSON: You're welcome.

CHAIR PARTIN: The next is approval of the minutes. Have you all had a chance to look at those?

MS. BRANHAM: I'll make a motion for approval.

CHAIR PARTIN: I don't think we can approve the minutes because we don't have a quorum. So, we'll have to leave that.

Under Old Business, we have some issues that we'd like to address, the first one being the issue of the APRN locum tenens. The recent Medicaid regulations that just went through the ARRS did mention the locum tenens as far as an APRN serving as a locum

tenens and billing under their own provider number.

And I know that the Department is going to begin working on the APRN regs, and we've been assured that there will be some modifications there to include APRN locum tenens. So, we are very grateful for that. We think that that will help to improve access to care for Medicaid recipients.

Another issue is the MCO policy to remove APRN's as participating providers if the physician who has signed a prescribing agreement with an APRN is not also credentialed with that MCO.

And I have heard from MHNet, Coventry, Humana, WellCare and Anthem that that are all changing their policy so that APRN's will be credentialed even if the physician who has signed a prescribing agreement is not participating with that MCO.

And I have not heard from Passport officially but I've been told that Passport does credential APRN's regardless of whether or not the physician who has signed the prescribing agreement is participating, but I'll have to get that in writing from them before I know that 100%.

But, again, I think this is an important move since more and more APRN's are opening

private practices and accepting Medicaid patients. And, so, this will also help to improve access for those people.

Another issue that was brought up in the Behavioral Health TAC recommendations and also that the committee brought forward at the last meeting was uniformity of preauthorization forms and procedures.

And there was a response from the Department regarding this, but I think that the question wasn't understood. The question is not preauthorization is required similar - how do I say this - similar authorization procedures is required across the board by the MCOs and Medicaid.

We know that and we know that the similarity as to what's required to be preauthorized is there, but the problem is is that the procedure in order to get the preauthorization done varies from MCO to MCO and with Medicaid.

And what we were asking for is some kind of uniformity in the procedure itself for the preauthorization, not that the things that are required to preauthorize are so different. That isn't the problem. We know if you're going to get an MRI, you're going to have to have it preauthorized by just about any insurance company that you're requesting it from. But

the way you have to go about getting that preauthorized is crazy, different from all of the organizations.

And, so, that's the question, and what we're asking for is some uniformity in the procedure that you have to go through in order to get the preauthorization.

So, since we have already asked this and we have already asked the Department for a response on this, even though we don't have a quorum this morning, I would ask that the Department re-look at this question and come back to us with an answer.

At least if there could be some similarity in the way that you do it because it's difficult for the providers and it's difficult for the staff of the providers who are requesting these preauthorizations to get it right because it's so different from company to company. So, if we could have some uniformity there, that would be very helpful.

And, then, the next item under Old Business is selection of health indicators, and Dr. Langefeld was going to provide us with information.

DR. LANGEFELD: Good morning. So, as context for this discussion this morning, as you recall or I think as you know, under contractual requirements with the MCOs, they all are required to

submit yearly what's called Performance Improvement Plans which really lay out a strategy for improving quality and health indicators for their population going forward. And, so, they have done that and met the obligations of that.

One of the issues around that, though, is, as we have increasing numbers of health plans, now with five, that that becomes an exponential issue when you have two and there are two different ones for every plan.

Then as providers, and, in fact, you just referenced it, you get all these different things occurring and it becomes somewhat overwhelming and unmanageable. And ultimately the issue is you don't accomplish anything at a population level which is I think where we want to be.

So, what Commissioner Kissner requested was that beginning this cycle for the next measurement period, that one of those two Performance Improvement Plans be harmonized or the same across all of our health plans. And, so, the request was for the committee to give some guidance as to what that one common area of focus should be.

So, we discussed that a little bit. I think there was some conversation, what you

asked is if I would come and provide some information or backgrounds for your consideration as you made that recommendation.

So, today, in your binder actually under Tab 11, it's actually right in front of Tab 12 - and I apologize, we do not have AV equipment in here for everyone to see this - it is titled Quality Improvement Recommendations for the Medicaid Advisory Committee.

What I want to do is walk you through - and stop me if there are questions - but I wanted to walk you through and give you some bits of information for consideration as you think about this recommendation.

And, so, let's just move through it. So, the second sheet really focuses on what I mentioned last time and that's our National Quality Strategy. It's amazing to me when I go around and talk to different groups how many people don't realize we have a National Quality Strategy that's articulated.

In fact, it was published April of 2011 and it is envisioned in what a lot of people reference the Triple Aim. And as you see here, the focus is better care for individuals, improved health of our populations and what I like to call financial stewardship. The original term was reduced cost. To

me, dealing with costs is a stewardship issue for all of us of how we handle and manage financial resources most effectively. Ultimately, we believe that better care and better quality actually will save money, but it still a stewardship issue.

And the six goals under the National Quality Strategy you see here, and I won't spend a lot of time, but it talks about reducing harm caused by delivery of care, strengthen person and family engagement, promote effective communication and coordination of care, work with communities to promote healthy living and make care affordable.

And, so, the next slide really gives some information. This actually was published about two weeks ago or came out about two weeks ago, and this is an update - this is from the Commonwealth Fund - this is an update of a look at Kentucky as it relates to overall state health system performance.

And as you see here, Kentucky is in what's called the bottom quartile, so, the bottom twelve states around the ranking as this particular study looked at it.

And if you look at the next page which is page 5, their focus was on four different dimensions - access and affordability, prevention and

treatment, avoidable hospital use and cost, and healthy lives. And the table you see really just summarizes from the last measurement period which was 2009 to the current how many states have actually improved, how many have had no change, and how many have worsened.

And visually you can see - and we don't need to spend a lot of time - but visually you can see that most of these measurements or these parameters under these dimensions that there was either no change among the states or a worsening of that. So, collectively, even as a nation, we've moved the meter very little, unfortunately.

And the next page, page 6, actually takes a look specifically at the states. And as you see, the measurement in 2009 compared to other states across these dimensions, in 2009, Kentucky was 40th, and in 2014, Kentucky is 42nd. So, this is one way to look at it.

The next page, page 7, is the America's Health Rankings. Now, you've seen and heard a lot of this. Commissioner Kissner has gone over this many times, I think. This is his thank goodness for Mississippi slide, right?

Now, as you see, Kentucky is here in blue. Now, sometimes when you see bl1ue, it's not

good. Most of the time it is, but in this case, the America's Health Rankings, we are in the bottom again in these rankings.

And what I would point to on the next page, on page 8, overall, our quality ranking in the America's Health Rankings was 45th. The previous year, it was 44th. We have never been outside the mid-forties for the length of time this particular measure has occurred.

And you see the specifics, and we all know many of these, smoking 50th or 1st, depending upon how you're looking at it, cancer deaths per thousand, preventable hospitalizations per thousand, poor mental health days, 49th, poor physical health days, 49th. So, proportionately or on a comparative basis, that's where we rank.

Now, I highlighted the ones at the bottom because I think that those are the ones that relate to our children and youth. And in that area you see, it looks at things like children in poverty and education but also immunization rates and pre-term birth and infant mortality and low-birth weight and teen birth rate and youth smoking and obesity in youth. You know, our children are our future and these are areas that we really need to be mindful of.

The next slide is a chart of obesity and just visually you can see again that we rank among those with the highest percent of obesity in that 30 to 35% range.

The other thing I would point out on this chart is that, unfortunately, that 15 to less than 20% number you see, there are no states, none, that are below 20%. So, even on a proportional basis we're the highest, but there are none below 20% nationally.

And the next page you see Obesity in Kentucky, the child obesity rate is 35.7%, adult obesity 31.3%, physical inactivity rate 29.4%.

The next slide just gives a summary. This is a mapping of all of the children in Medicaid and our children's Health Insurance Program, over 570,000 children. You see there are no counties with zero children in them. So, this is across every county, all 120 counties in our state and how many proportionately we see in those counties.

And the next slide, I think, really, then, gets to one of the points related to children. Forty-two percent of all of Kentucky's children are covered by Medicaid or KCHIP. Now, overall, I think as you know, close to 25% of our total population with our expansion numbers are in Medicaid,

period, but in children, it's 42%.

So, let's talk about that a little bit. One of the issues and areas for consideration is psychotropic medications. These are medications for treatment of things like depression or hyperactivity, ADD/ADHD, the antipsychotic medications. If we look at our children, if we look at the total number of children in our state, 42% overall, 14%. So, over 82,000 children of our children have prescriptions for a psychotropic medication. That's almost double what other states on a comparative basis, so, almost doubled compared to other states.

And if you look at our foster children, we're at 42%. Forty-two percent of our foster children have psychotropic medications prescribed, again, compared to an average of 26%. Now, to put that in context, there already is a national concern about the treatment in foster children at 26%. And, so, we're at 42%.

So, I will get off my grandstand for just a minute related to that and talk about ADHD treatment. So, if you look at those children who have had a diagnosis or have been told they have a diagnosis of ADD/ADHD over a period of time starting in 2003 forward, you see really a divergent curve. So, we're

now right at 19% of our children who have been told they have a diagnosis of ADD/ADHD compared to a U.S. average of 11%.

And if you look at those that are taking medications currently or actively for ADD or ADHD, we're at 10%, the second highest in the country. In 2007, we were seventh and now we're the second highest overall as it relates to the treatment of ADD/ADHD with medications.

CHAIR PARTIN: Can I ask a question?

DR. LANGEFELD: Absolutely.

CHAIR PARTIN: Do we have an explanation for that? Has it been looked into as far as are providers just over-prescribing or do we have a problem with our children? Could it be related to the parents?

DR. LANGEFELD: Well, as I think your question reflects, there are multiple questions and issues around this. And I think one of your questions is, are we different than other states? And the answer is, it depends. If you look at different areas of our states and our issues around social determinants, and as we mentioned, the environments the children are in, sometimes there's a wide variation across the state, but

that's true in every state. It's true in every state.

So, the ultimate answer to your question is it is something that we need to take a deep dive on, in my opinion. If we look at all of the issues, Dr. Neel, children are the future, right?

And this, if I were to rank things personally and professionally, this is a burning issue. It needs to be understood. It needs to be understood if there's a reason that we're at such a variance. It needs to be understood if we need to address it in a very comprehensive way.

DR. NEEL: Have you already appointed a committee or somebody to look at this because this is a pretty complex problem?

DR. LANGEFELD: It is.

DR. NEEL: And some child psychiatrist would say we're actually under-diagnosing ADHD and that we should have more. But the question is, do all of these kids need to be on medication?

I can tell you that the providers, particularly the pediatricians, are under the gun from teachers in particular. They actually tell the parents, Johnny can't come back until the doctor gets him on medicine. Medicine has always been only a part of the treatment of ADHD, but now we're over to the point where

it seems to be 90% of the treatment and it shouldn't be.

And another issue that people don't know about often is that the question of disability. If a mother can play her cards right, she can get her child or children declared disabled because they have ADHD and then she gets disability payments which I've worried about for years. So, it becomes pretty complex and affects more than just the child and his treatment.

DR. LANGEFELD: You're absolutely correct, and that's why it is not simple. It's not straightforward. There are multiple issues here.

The answer to your question is yes. We're taking a pretty deep-dive analysis at our data. We're engaging in discussions with our academic institutions around this to get feedback and guidance relative to how to approach this in a very thoughtful way and a way that makes sense. And, so, yes, the answer is yes to that.

DR. NEEL: The lack of mental health providers also has made that much more. I wanted to add that particular thing because I know in my particular area, it's very difficult to get a child in. There's nothing between me seeing them and a child psychiatrist seeing them. We're having trouble because

the psychologists are not there that could actually help us. We just don't have enough.

DR. LANGEFELD: Right. Absolutely.

And we can discuss this some more. I just wanted to give you kind of an overview of several areas. We have what I will call a target-rich environment, right? We have multiple opportunities.

So, let's talk about smoking and there are many levels of smoking, but let's talk about smoking and pregnancy. Smoking during pregnancy, prenatal smoking is associated with 30% of small for gestational age infants, 10% of pre-term infants. And Kentucky historically has been the second worst rate of smoking and pregnancy among all states.

And if you looked at the charts, you can see just a summary of percentage of Kentucky resident women who reported smoking during any trimester, and you can see that we are well above the U.S. rate, the U.S. rate being in the last measurement period 10%. We were at 22%.

If you look at children in households where tobacco is used, U.S. average nationally was 26%. We're at 40%. If you look at smokers versus non-smokers, infant mortality rate due to

Sudden Infant Death Syndrome by smoking status, that proportionately it's almost double when you have a smoker in the house. So, smoking period but certainly smoking during pregnancy.

The next slide looks at pre-term birth. So, pre-term-related causes of death are the leading cause of infant mortality in Kentucky - the leading cause of infant mortality in Kentucky - and the nation accounting for 35% of total infant deaths.

And our pre-term birth rate in Kentucky has increased 8% over the last decade. You can see the chart below. We went from 12.7% to 13.7%. And we are again above the national average on an every-year measurement in pre-term births.

So, this gets at a lot of issues including things like early elective deliveries. I know some of the hospital associations that are looking at this as well, but it is an issue. It is directly related to infant mortality and morbidity and mortality overall in infants.

So, the next slide really gets at behavioral health. More than 1,000 Kentuckians die each year from prescription drug overdoses. That's an escalating number. And in the last measurement period, Kentucky is the third highest in the nation in overdose

deaths. One in five teens has admitted to using prescription pills for non-medical reasons.

And you see the chart below that looks on the basis of the distribution by county. And there are very few counties that have had no deaths related to drug overdose.

The next slide really just gets at a higher level. One in five people have mental illness or drug addiction. And people with mental illness die earlier than the general population and have more comorbidity, more occurring chronic medical conditions. Sixty-eight percent of adults with a mental illness have one or more chronic physical conditions.

And the other thing is we know that treatment works. You can see at the bottom. People who get treatment, it is effective.

Of course, it's one of the issues that is being addressed in our current expansion of services and encouragement and active encouragement in developing our care continuum for behavioral health services in our state under our State Plan Amendment, the expansion of that, the coverage for treatment of addiction.

So, the resources are there from the standpoint of coverage. The issue and concern is

how do we develop the continuum of care in our communities. And this is not just a Medicaid issue. This is an issue for our population. It's an issue for Kentucky.

The other issue I want to address when we talk about holistic care, we can't separate the head from the body. So, mental health is central and core to this discussion, as is oral health when we talk about holistic care.

So, oral health is an area that's been identified, and a lot of this has to do with access. And you see in the slide here our dentists per thousand, our distribution across the state which continues to be a challenging area for our dentists. We've had multiple conversations there. Our number of pediatric dentists even more critical.

There are a number of initiatives in the state -and you see the next page - that are actively pursuing improvement in this. And I won't go through all of them but I'll mention things like community fluoridation, our fluoride varnish programs, the sealant programs. So, there are a number of resources that are out there and available, and, so, how to connect and reinforce the need for a more comprehensive oral health program.

So, with that, and I'll move on because I just wanted to give you a sampling of some of the things that were behind some of the numbers that you see pretty frequently. But I want to move on to kind of a high level.

How many of you have actively seen or been involved with the Governor's Health Initiative, Kentucky Health Now?

CHAIR PARTIN: I've seen it.

DR. LANGEFELD: So, the Governor, it's almost two months ago now, announced the initiative Kentucky Health Now as a vision for where we can and need to go in Kentucky. And he outlined, as you see in this slide, seven high-level goals. Most of these are around a five-year window.

And those specifically, as you can see here, Kentucky's rate of uninsured individuals, less than 5%; reduce the rate of smoking by 10%; reduce the rate of obesity by 10%; reduce cancer deaths by 10%; reduce cardiovascular deaths by 10%, reduce the percentage of children with untreated dental decay by 25%; reduce deaths from drug overdose by 25%; and reduce by 25% the average number of poor mental health days of Kentuckians. Remember, we're 49th mental health days.

Now, a lot of people's response

I've heard to this is, well, those are just numbers. Well, yes, they are just numbers; but this is, I think, a very important thing because it gives us something to sort of collectively think about how to focus on together.

And the reason I put it in here is because some of the considerations that we all should be focused on, when we talk about a National Quality Strategy, what is Kentucky's Quality Strategy? It should be in alignment because hopefully we're all focused on similar things, but I wanted to really highlight the fact that we have articulated a vision for where we hope to go at a Kentucky level.

So, there are seven high-level objectives on this sheet. There are 58 sub-strategies under that, and actually I included them in your packet. We won't go through all this today unless you'd like to but just for your information. So, in the back of this section, you'll see all of the sub-strategies under each one of those high-level objectives.

So, the next slide, I wanted to give to you a summary of where we've been already. So, as I mentioned, by contractual requirement, the health plans have submitted and you see a summary of the Performance Improvement Plans that have taken place

historically. So, you will see a summary here.

So, I just wanted you to have a sense of what those were. And a lot of them are already around things like depression and ER utilization and prevention by supporting families and children with ADHD and avoidable re-admissions. So, you see some common themes to what I talked about before.

It also highlights the fact that there's a lot of variation there as well. And, so, how do we, particularly if you have people that move in and out to different plans, for example, and are being measured in different ways, how do we get some consensus around our whole population in Medicaid. So, here's a summary just for your consideration of what has been done or what's in process today.

The last sheet that you have here is really a summary. We did ask our external quality review organization who works with the Department and the managed care plans some thoughts about what they've done or been actively involved with with other states.

And, so, what you see on that last slide before the detail of the Kentucky Health Now is a summary of some of those thoughts and some of the things they've seen and other states have been focused on. We've referenced it before - ADHD treatment, childhood

obesity, preventable dental services, pre-term birth prevention, cervical cancer screening, drug overdose prevention, well-child exams and tobacco use and cessation.

So, I guess my objective today was to respond to the committee's request to say where are some opportunities, what are some needs in our population or as Kentuckians? So, I wanted to give you some ideas and thoughts about that.

I think the ask again is your thoughts about what that one could be. And it may be that you come up with two or three or five - here from our perspective are some high-level issues that we really need to address.

And then we can work together and I can work with the plans and the Medical Directors to say what are some ways we can begin, how should we prioritize this. So, that's a potential way to move forward as well, but we do have some time sensitivity around this.

The decision on what that one will be for our next cycle is due by September 1st. And, so, we certainly would need some recommendation by our next meeting. When is our next meeting? July.

MR. FOLEY: What does it mean on

the PIP Summary when it says completed, like it lists out, for instance, on Passport?

DR. LANGEFELD: When they put a plan out, they say we're going to study this for "x" period of time, a two-year period, right? And, so, you see there that it started in 2006 and it was completed in 2009. So, there's a report. And certainly if you'd like the results of that report, we can get that to you, but that's what that means.

MR. FOLEY: So, nothing is put in place. It's just a study.

DR. LANGEFELD: No. What's put in place is a programmatic design about the issue and how it can be approached and what resources are needed to help support and/or change activity or decisions or how to improve ultimately the outcomes.

CHAIR PARTIN: So, we will need to look at these. I think the committee will need to look at these, and I'm not sure. I guess I need to ask the question. If we need to come up with something by July, how do we do that? Can we have some kind of informal discussion online or do we have to meet in person? I guess I need some guidance on how to do this.

DR. LANGEFELD: I'm not sure how to respond. I guess if the committee has----

COMMISSIONER KISSNER: You assign it to a TAC. You could do that. You can assign it to a TAC. The TAC makes a recommendation to the MAC. The MAC when they have a quorum approves the TAC minutes or the TAC suggestions. That's one way is you let the TACs, like Primary Care. Almost any of them could handle this as an issue but that's one way.

We would not recommend violating the open meeting laws. So, you can't really do it on email because you can't have the world open email. So, you need to get it through a forum. That might be the only suggestion, or you just talk about it here and have an open discussion here and then vote as well.

The other thing is we could come back with a formal recommendation from DMS and say here's our opinion and you can vote on that. We could say we pick one. Here's what it is. Here's what we think in talking to the Cabinet what we think is most important.

I can tell you it will be something that we've just gone through, for sure. It won't be anything new, but it would be one of these, and this is the one we think is the most hot and pressing issue and we'd like to make that one of the two PIPs. We'll make it the common one. That's the other option

is we could make a recommendation to you and then you could vote on that recommendation as well.

DR. NEEL: I think that's what we ought to do because they have the statistics. And even a TAC has the same problem of open meetings that the MAC has. So, we've had very difficult times having those.

So, it looks like to me we could have a little discussion at the end of this meeting, but I'm very happy with what they've done and it looks to me like if you all agree, that they could pick one because we're going to basically pick one or one with some other caveats in it.

Childhood obesity, of course, stands out for me because that's one of the worst things we've got that we can work on, but if they could come back with a recommendation, I'd like that. That's my suggestion.

MS. ROARK: I would like to say I was noticing that I don't hear anything about heroin. We're having a big problem with that.

DR. LANGEFELD: Heroin would fall under drug overdoses. And you're exactly right, we have an escalation. We have been and continue to be concerned about the use of opiates and prescription abuse.

One of the things that has occurred that some people would suggest, that sort of the clampdown on prescription medications. We've seen an escalation of illicit drug use like heroin and we have regions in this state of very active heroin utilization, as it sounds like you're very well aware.

MS. ROARK: Well, I know you hear about cutting down on the pill mills and all this stuff, and I don't agree with that, but personally I don't think you catch Hepatitis C and all these other things from taking a pill.

Since they've cut down on all of that, the heroin especially, I've joined a group in Covington, Kentucky. They're on the street. It's getting bad. And I just recently met this guy from 100 Pedals. I was I guess on TV the other night, and he's traveled from state to state, and I asked him his opinions, do you see this in every state or is it more here in Kentucky. He said it's everywhere.

The good thing about Kentucky that we have some treatment centers that Arizona don't.

DR. LANGEFELD: It is an escalating issue nationally, but Kentucky is in no way exempt from it. You mentioned Northern Kentucky. We're the third highest in drug overdoses. That's not

prescription drugs. That's drug overdoses including illicit drugs.

For example, looking at people who utilized the emergency room a lot which we've done, in Northern Kentucky, overall, almost 80% of people who utilize it at a high rate, let's say ten or more times a year, will have a behavioral health diagnosis and 45% of those will have a substance abuse diagnosis. In Northern Kentucky, that number is 95% behavioral health and 81% substance abuse. So, there's some variability but it certainly is an area that needs our attention, all of our attention.

MS. ROARK: And I would also say that I have a son with ADHD and I had a doctor tell me once that smoking causes ADHD. I didn't smoke or anything, and then it's inherited.

I don't think any parent wants to put their child on medication, but when the school is calling and your son almost gets ran over, there's some things; but I do agree that some people are abusing the system and saying that maybe a child has it and they don't and there's some parents, as Dr. Neel said, maybe wanting to sign up to get disability.

DR. LANGEFELD: I mean, your point is well taken, and what it reinforces is we all need,

all of us need education. We need to understand appropriateness, effectiveness, what are the things that need to be assessed to really diagnose appropriately, and what are the factors that we need to assure before medication is prescribed. So, education is a fundamental part of it.

MS. ROARK: And a pill is not going to fix it all. They need therapy. Thank you.

DR. LANGEFELD: Absolutely.

CHAIR PARTIN: Does anybody else have any comments on any of these measures? What's the pleasure of the committee? Dr. Neel has suggested allowing the Department to make a recommendation to us for the next meeting.

MS. BRANHAM: I would agree with that.

CHAIR PARTIN: Okay. We'll do that, then.

DR. LANGEFELD: We'll do. Thank you.

CHAIR PARTIN: Next on the agenda is Updates from the Commissioner.

COMMISSIONER KISSNER: We should add that on the heroin topic, I think Senator Stine this past Session had a bill that we looked at and we were

supportive of that had a couple of things in it, and one of them was sort of a Good Samaritan clause that said if you're with somebody and they overdose, that you call 911 and the cops don't arrest you because you're both sitting there using heroin. You're trying to do the right thing and save a person's life. So, there was a Good Samaritan clause in there.

And they tried to build in that if like a minimum amount of illicit drugs was on the scene, you wouldn't bust them for that. You just deal with the issue because the goal there was to save a life, save a life first and then deal with the other stuff second.

And the other thing is we worked with NGA. Dr. Langefeld, the kit----

DR. LANGEFELD: There is a lot of discussion around the utilization of Naloxone which is an antidote. It's essentially an antagonist to opiates and heroin. So, you can reverse the effects of that very rapidly with Naloxone.

Now, Naloxone has been around for a long time. It's been covered for a long time. The issue is getting it into the hands of people to use it - first responders, family members, all of those kinds of things. The issue around a legal buddy system, that was something that was addressed.

We still have the hurdle to address some of the legal issues and liability issues around things like first responders, etcetera.

COMMISSIONER KISSNER: Police, firemen, EMTs.

DR. LANGEFELD: Police, firefighters, EMS who can use that at the site when they don't have a prescription for that person specifically. Does that make sense?

So, it is an area that we are continuing to talk about. There was a bill introduced that did not pass. We thought it would. But we would encourage your support in dispersing that, particularly in light of our epidemic that we do have.

COMMISSIONER KISSNER: So, it's like an epi pen. So, you carry it in your toolbox, that little tackle box that most EMTs have. You open it up and you grab the pen and you inject it right away and it neutralizes the opioids - that's the basic, non-clinical thing I think about - which could save a life, but there's a lot of hurdles to use that prescription for someone that doesn't have that1 prescription, and I think that's really the issue.

This has come up in a number of states and the National Governors Association has

identified it as an issue that we need to keep pushing because that's what we want to have happen. We want to be able for them to act, do the right thing, save a life. So, distribution of the pens and having it fit within Kentucky law, that's where we're pushing that.

So, on the binder, I'm going to go through this really quick and just stop at a few things. We have all the letters from CMS, Section 1.

Section 2 is our letters to CMS, and basically the only one I wrote since the last meeting was to ask Jackie Glaze at CMS about House Bill 527 which was passed about how do we get the primary care services delivered at a CMHC setting if it's an outpatient mental health, the single source for a long time of outpatient mental health in the state for Medicaid.

And, so, if you're treating the mind, can you treat the body as well? How do you do that? Does it impact the federal percentages, and are there any rules? We have not heard back yet on that but we're trying to make sure we can do what's in the law.

Section 3 represents the different corrective action plans or letters of concern both to an MCO and from the MCO.

Section 4 is the dashboards that

we have from the various MCOs.

Section 5 represents the network adequacy review on the various MCOs.

Section 6 is a big section because this is the changes in the network. Coventry and WellCare are fairly stable. Humana, Passport and Anthem are adding lots of providers into their network to participate.

As an example, we expanded the provider types who can do mental health. So, prior to 1/1, we did not recognize a psychologist, a marriage, family, child counselor, an LPP, the master's level people. We didn't pay them directly. We paid the CMHC's. The CMHC's paid them. We also didn't recognize physical therapists or occupational therapists or speech therapists. So, we would pay somebody else and then it would flow through to them. They were not recognized provider types under the Medicaid regs.

So, we opened up the network and there's as many as 800 new providers that have signed up under Anthem and WellCare. We had 400 individual providers write us emails and say we're supportive of you opening the network. They were basically psychologists, marriage, family and child counselors, master's level practitioners who have in every other

form of healthcare, commercial or individual, they have the right to practice medicine in the state under the scope of their licensure, and we just didn't recognize them in Medicaid. So, we opened up the network.

So, that's been pretty significant and there's been a lot. And, then, Passport and Humana both got a statewide contract with Anthem as well. So, that's a lot of the growth there.

DR. NEEL: May I ask a question? There's a lot of confusion amongst a lot of us, physician providers in particular, about what's happening now as far as open enrollment for our patients that are in Coventry and WellCare being able to change to these others when many of us are not knowingly in their networks.

Most of us are not in Passport's network. And, then, a lot of us are in Humana and Anthem's general networks but we don't know if we've been put into this network or not because we did not get an addendum to a contract or something that tells us what fees might be and that sort of thing. Can you enlighten me on that?

COMMISSIONER KISSNER: Open enrollment is taking place now. Is Jill here?

MS. HUNTER: Yes, right here.

COMMISSIONER KISSNER: So, the dates are?

MS. HUNTER: The dates are May 5th through June 18th, not for Region 3, not for XA or XF. Those are the folks that came in through the Kynect.

COMMISSIONER KISSNER: Right. So, May 5th through June 18th, we're having an open enrollment and that's for everybody outside of Region 3 who we basically had two choices. Remember when Kentucky Spirit left. We just had WellCare and Coventry. So, we spun the Wheel of Fortune and we divided people up. We tried to assign them to keep the families together. We tried to do all those algorithms but basically this is their opportunity to say now for 7/1 effective date, they can make a change and change to any of the five if they want to do that.

Now, we don't control that. We send information. It's up to the member. It's total member choice. And if they don't do anything, they don't change. They have to actually take action and say I want to change and I want to change to "x". They have to do that.

So, we need to have an open enrollment every twelve months according to CMS. We asked them if we could stretch it out a little bit and

they said no. So, we're going to have all the people that signed up for ACA expansion, the new enrollees, effective 1/1, they need an open enrollment, too at year end.

So, what we're going to do is we're doing one now and then we're going to do the whole world of Medicaid, the state, at year end some time - we haven't figured out the exact dates yet - but we're going to do an open enrollment then, and it will be effective 1/1. And, then, we'll have everybody on a 1/1 cycle because the rest of the world was on a 7/1 cycle, an 11/1.

When we started, it was on a 11/1 cycle, and then Region 3 was on a 1/1 cycle and we're a little off by a few months because we started on 11/1 of '11 and then we moved managed care 1/1/13 in Region 3. So, we were off by just a few months.

And then we had this issue of really wanting, when Kentucky Spirit left on 7/1 of last year, 7/5, we wanted to have an opportunity. So, we promised in our contracts that the new players would get to play in old Medicaid on 7/1 of '14. So, that's what this open enrollment period is about. If they want to make a change, they can.

And with respect to your

contracts, that's a discussion you have to have with your MCOs. I can't speak to your contract. Some contracts allow for changes. Some require a signature to do amendments. Some require 30 or 60 or 90 days' notice without an amendment. It varies by contracts that are signed.

So, I think I would get to the MCOs that you're interested in and confirm that you're participating or not participating. That is something you can discuss with your members. You can tell them which ones you're participating in. White collar marketing, you're not supposed to influence. You're not supposed to say we really want you to go over here, but you can say I am participating in these two plans. That is acceptable. You're allowed to tell your members what plans you participate in.

DR. NEEL: How about on the other side, though? Are the recipients just getting a letter from DMS that says you now have the right to change to one of these other three if you wish, but are they getting information from the three new companies that say you might want to come to us because we don't do copays, for example? Is that allowable?

COMMISSIONER KISSNER: They're allowed to do advertising. They have some billboard

advertising. We approve all ads. It goes through an approval process. They are allowed to advertise. Some have taken a billboard approach. Some have taken a bus approach. Some have taken some radio ads, but we do make sure they stay within the marketing guidelines. We do audits of that. We approve the ads and we do audits of their community affairs.

One of the things we're working on is a common calendar of community events that we're going to start publishing in advance on our website so that everybody knows here's the five MCOs and they're going to be at the Strawberry Festival and the Garlic Festival and they're going to be over here, whatever. So, everybody where they're going to be where they set up a booth and can talk to people. We allow that.

You can't go door-to-door, knock on people's doors but you can set up in public forums; and if people come to you, you can talk to them about your benefits and what it is and there are differences. So, we've outlined those differences in the material that we put, whether they have a copay or don't have a copay and it's ultimately the member's decision.

Letters from the MCOs to the members, they're not doing that. We did the communications. If they're not on the list, they don't

know who to market to.

MS. BRANHAM: Is it true that a majority of the letters that DMS sent out were returned?

COMMISSIONER KISSNER: There is a percentage.

MS. BRANHAM: There was like a large percentage.

MS. HUNTER: It's less than 5%.

COMMISSIONER KISSNER: Since the last time we've done it because we did it all last year. When we're doing it once a year and we did research once a year, at some points, we had about as high as 30% returned mail. But now that we've got the MCOs and the MCOs are in more constant contact with the member actually talking to them about disease management, case management, they get a better address, better ways to contact them.

So, we're working now on a project to see how we can make sure that we get the most current data on where they live. Medicaid is a fairly mobile population; but because of the frequency of which we've been communicating and when we get returned mail, we discuss it with DCBS who can help us find the member and get it cleared up.

So, we had a very small percentage

the last time. The most current mailing, we had a very small percentage.

MS. BRANHAM: So, then, really, the MCOs relied on you to send the communication out, and, then, their campaigns for open enrollment, then, will be what has the recipients to choose.

COMMISSIONER KISSNER: What you see in public media. So, on TV, radio, print, ads, billboards, that's their marketing campaign and they do attend fairs and country fairs and events. They'll be there.

DR. NEEL: The problem we're seeing so far and I just want you to know that is the people who are tending to change are those that have some special problem and they find out that maybe Anthem or Passport will cover that whereas the other older MCOs don't. So, they tend to want to change.

But the problem is, then they don't have a doctor because so many of us are not in the new networks, at least not yet. So, just know that that is an issue.

COMMISSIONER KISSNER: And when they call us, we tell them about that. We say make sure. We have links on our website to the MCO directories. So, make sure your doctor is participating

in the network. We do make that statement like a thousand times a day.

CHAIR PARTIN: I was going to ask this question later but now that we're talking about it, none of the providers were notified about the open enrollment, and this committee wasn't notified about the open enrollment.

COMMISSIONER KISSNER: I apologize for that. I thought we mentioned it.

CHAIR PARTIN: We didn't know about it.

COMMISSIONER KISSNER: We're in the 5/5 to 6/18 to open and there will be another one at year end. For the record, there will be another one sometime in October, November.

CHAIR PARTIN: Would it be possible to notify the providers as well because I've run into this problem before because there's a fair number of my patients who can't read. So, it's really helpful for me to know if they're getting letters and I can ask them, did you get a letter.

COMMISSIONER KISSNER: We can get that out. We can get that out probably within a week. We'll get it out while it's still during the open enrollment period. We'll get it out by the end of next

week. We'll do a mass to all provider types. Jill, that's a take away.

MS. HUNTER: Yes. That's on my to-do list.

COMMISSIONER KISSNER: Section 7, and I briefly mentioned this, these are letters to each of the CEOs about our IPRO reports. So, the letters are exactly the same; but if you skip to the IPRO report after those letters, the first one is an IPRO Final Report, January, 2014. It looks like this and it's the postpartum re-admissions. This is a good read.

What happens with postpartum re-admissions? Why do they happen and what's the percentage and are there things you can do to improve that? So, that's a study there.

The next one is newborn re-admissions. Now, the take away - I am the farthest thing from a physician there is - so, the take away is if you do anything to the baby while they're in the hospital, if you stick a tube down their throat, if you do anything, or the mom is a teen, or the baby is low birth weight and if you do anything other than swaddle them and feed them, right, there's a chance, it doubles or triples the chance that the baby is coming back to the hospital.

There are certain factors prior to 37 weeks, if the delivery is prior to 37 weeks, it doubles or triples the chance the baby is coming back. So, those are the things that I sent to the MCOs and said, hey, figure out a way to track this and be on the alert because there's a good chance if any of these factors - a teen mom, a low birth weight, an early pregnancy or something is happening while the baby is in the hospital where they are doing something additional to the baby - if any of those things happen, it doubles or triples the chance the baby is coming back - readmit.

So, figure out a way to get in there and help and manage and educate and see if there's additional services that need to be or help with additional home health care visits because those seem to be the triggers.

The next one is a validation report of the managed care performance measures which was finalized in March.

We also have a report that's the independent assessment of the non-emergency medical transportation. We have sent that off to CMS for their review. We have to do an independent assessment of both the non-emergency medical transportation and the managed care contracts. So, they've completed their managed

care contracts. I'll give you that assessment at the next go-around and we've sent that off to CMS as well. I just don't think it made it into the binder.

You've got the good news' stories. Those are always interesting to read. I'm not going to read any of them to you.

Section 9 is the letters to providers. We're going to push the nursing home payment from June to July. We've done that every year. It's a cash management issue. We're going to push employee payroll checks another month from the end of June to the beginning of July. We're going to push the MCO payment from June to July.

So, instead of making the normal $500 million payment to the MCOs, we push it to July and we make two payments in July so that we get into the next fiscal year.

I'm meeting with the Governor this afternoon. We have a budget problem and we need to talk about what we're going to do to help achieve our Medicaid budget because right now it doesn't look good. So, we'll figure out that and I'll report back on that to you.

I did mention it last time on the budget. We talked about that at the last meeting. I

gave you the budget analysis that the Senate had done. I gave you that analysis. We talked about it. Well, nothing has changed. So, we have a budget problem and we'll be addressing that. So, anyway, that's what that letter is and there's other letters there about communications.

Now, there's new federal rules on home- and community-based waiver services. And one of the things is that the basic concept is they changed and they said somebody with home- and community-based service, we want them to be the most home- and community-based service you can be, which means even if you're in a building that's a personal care home or you're in a facility that has beds and you're staying there, you have to be able to lock your door. That's what keys are made for.

So, people need privacy. They need to be able to pick their roommate. They need to be able to have the normal landlord/tenant protections that happen. So, they've made significant, significant changes. It was three or four years in the making, three years of public comment, and the rules were delivered on March 17th.

So, CMS has pushed out and said you guys with your waivers, home- and community-based

waivers, you need to be compliant in these areas. We need to make sure that people have rights. They're not prisoners. Just because they're in a facility doesn't mean they're locked up. You can't use chemical restraints. You can't use real restraints. You've got to give them freedom of choice. If they want to get a private room and they have the resources to pay for that, you've got to let them do that. They need to be able to choose their providers.

So, that's the basic concept. So, we're asking a number of questions and trying to figure out how we're going to comply with that. And, so, part of it is asking questions to the providers to say we need to understand how you operate, and do you have a tenant/landlord agreement when somebody is there and you're taking care of them? Do you have something like that? How do you afford those protections? So, we're asking questions.

Section 10 is the benefits and copays. This is basically the material that went out to the members. And you can see there, we do it in English and we do it in Spanish.

The next section has a bunch of----

DR. WATKINS: I have a question on

that. And I don't know if I need to address this to you or to WellCare is the one I've seen this specifically come up with where on the ID card, it tells you what the person's copay is. And I've seen several children that they have a $3 copay that's listed per office visit. And I was noticing on their I guess advertisement here that it says no copays for physicians, zero copays for extra benefits. So, why am I having to charge these children $3 for their eye exam and glasses?

MR. WISE: KCHIP 3.

COMMISSIONER WISE: KCHIP 3. What does that mean? They have copays. KCHIP 3 has copays.

DR. NEEL: But WellCare has admitted that they somehow made an error. And, so, many, many of our children who are not on KCHIP have had that on their card.

COMMISSIONER KISSNER: Right, and I think they corrected that.

DR. NEEL: Right. That's true.

COMMISSIONER KISSNER: They did. They mailed out new cards.

DR. NEEL: A lot of them haven't gotten new cards. It's still there. And, so, the providers are confused at this point. It will gradually work itself out but it's been a big problem.

AUDIENCE: Just to clarify. On the no copays, that starts July 1st.

DR. WATKINS: And that would apply to those KCHIP children also?

AUDIENCE: Yes.

COMMISSIONER KISSNER: Section 11 has some really interesting stuff. The first one is a letter from Erin who is our Chief Policy Advisor at Medicaid and Dr. Rich, our Dental Director to me about what's gone on with dental services and children being treated.

They did a lot of work to determine how much do we spend, what do we spend, what do we spend it on, how does our program compare to other states both nationally and locally. So, that's a very interesting read there. Again, all of this will be posted on our website for the public to read.

You've got the Dental TAC report meeting. You've got some TAC notes there. You've got the notes from Dr. Langefeld and his Medical Directors' meeting. So, if you want to know what's going on there, you can read through those notes. He meets every month. So, there's the March and April meetings there.

There's a spreadsheet - it looks like this - in there. Recently, there was a lot of

hullabaloo about the release of data from Medicare. So, just for sort of grins and giggles, we ran that data. We went to the public website, the federal website, and we pulled the data and we categorized it into these categories.

And we just looked at it like the top 100 as a percentage, the difference from the average. Now, this is Medicare data. It's not really labeled well. This is Medicare data. This is what was published. That's been in the paper over and over again. The Florida opthamologist that had $6 million of spend and the chiropractor in New Jersey who got like $5 million and there's no storefront and that sort of stuff.

But this is the Kentucky data that was published and we sorted it a couple of ways. We sorted it by the per unit cost and we sorted it by the percentage difference. So, it's just interesting data, public data.

There was a Clinical Focus Study - I'm not real familiar with this one - that's the EPSDT that Medicaid has done.

If you get further down, there's an email from Barbara. Barbara, I'm not sure why that's there. We tend not to include emails in this

binder. We do formal letters only. So, we won't be doing that in the future.

But if you get to the May 20th letter, this is in response to - I'm still in Section 11 - it's about two or three from the back, from the very end. It's right before Dr. Langefeld's presentation that he just went through. It's the three letters before that.

You guys had asked us, you said the prior authorization services. So, we went through and pulled all the data of what do the MCOs prior authorize and are they consistent.

And what we found, you can see here -Lee Guice and her team did this - and they put together and they said all services provided by non-participating providers across the board. Everybody prior auths that. Ambulance service by air and water, four of the five prior authorize that. Behavioral health and substance abuse services, across the board. Chiropractic visits, across the board. DME over $500 across the board.

So, the message here is that there is a lot of consistency in the areas that they are prior authorizing. And your point well taken is the methodology, the procedural is different and varies by

MCO, but what they are asking to prior authorize is very consistent.

The next one, this is the MCO appeal information, and we did the analysis here to say if somebody wanted to appeal, if the provider appeals, what are the requirements. Now, there's contractual requirements, so, here are the requirements.

So, like credentialing and network participation. So, time to file, you have 30 days and the response time is 30 days and that's consistent across all five of the MCOs. Medical necessity, it's either 30 or 60 or 90 days. So, you have that amount of time to make that appeal, and then the response time is 30 days. An expedited appeal is 72 hours across the board because that's a contractual requirement and those are things that we monitor.

And, then, the medical necessity post-service and payment, you can see that it varies from 30 days to 90 days to a year and as long as two years. And, then, once you make that appeal, they turn it around in 30 days. So, again, that was one where we were looking to see what the consistency was.

And the last letter from Lee - so, Lee's team did a lot of work here, or this is Elizabeth Justice, the Branch Manager - was on the MCO member

appeal. The other one was the provider appeal. And I'll say the caveat there is please refer to your own contract because you may have negotiated something different.

But, anyway, generally speaking, that's what happens, and this is the member appeal. So, the member appeal is, again, very consistent. Yes or no and calendar days or business days. That's what the B and C represents. And you can see there which we would expect a lot of consistency in this because this is a contractual requirement of our contract. So, we just put it there to show you what it was they do.

Now, where you see the nuances, the differences, they tend to be more liberal differences, not more restrictive. An oral appeal must be followed up with a written appeal. That's yes, and then one plan says no. That's more liberal. As you read through this, that's what that represents.

And, then, the last one, we talked about this. We did it in the meeting but we did not follow up in writing and confirm it, but primary care, primary care. Do you have to use a primary care? Can I go direct to a specialist? We asked them all.

The member must select a PCP, yes, across the board. Member can change a PCP by phone.

Yes across the board. Member may see a provider that is not the PCP. Yes across the board. Number of times a member can change PCPs without approval. It's basically unlimited. Effective date of the change, it's either within 24 hours or immediate, depending on the plan.

And referral necessary for specialists, yes on Passport because they use subcontract primary care docs. So, they ask that they get a referral from their primary care, but everybody else is what you would consider an open access plan. So, the primary care doesn't need to refer for the others to see a specialist.

And then you have claim denial for specialist with no PCP referral, and obviously it's the same as the prior one. If you require it, you're going to deny a claim if you didn't get it.

So, that I think will help providers understand what it is that they do and how they do it, and this is a key to understanding managed care and how they operate in the state. I believe these four items are like valuable cheat sheets for understanding in general terms what's going on and how they operate.

DR. NEEL: I might mention that we're seeing a lot of inappropriate referrals from

urgent care centers and even emergency rooms to specialists when they really should have referred them back to their PCP and then to the specialist. I see that happen at least once a week. It would give us better control because a lot of them are just really inappropriate, like to an ENT for big tonsils when we've been seeing them along and it's not necessary for them to go there.

DR. WATKINS: I also had a question along that line, too. Say if someone went to the emergency room because they had an injury to their eye, and that person is then told by the person in the emergency room that they need to go see their eye doctor within 48 hours or something as a followup after that, is that still going to require a referral from the PCP?

COMMISSIONER KISSNER: Only for Passport.

DR. WATKINS: But that would still be true.

COMMISSIONER KISSNER: Unless Passport wants to make a different--what they've told us is referrals to specialists require a primary care.

AUDIENCE: They do but eye services do not.

COMMISSIONER KISSNER: Let the

record state.

CHAIR PARTIN: One other point that I'd like to make in general just to I guess Medicaid and MCOs is that we've had a couple of cases where the patient has received a letter of approval for an authorization but we have not. And, so, the patient doesn't know what they have and we keep on trying to get approval because we don't know it's been approved. And then the patient comes in two weeks later and says I got this letter but I don't know what it is.

And, so, if you could make sure that the providers get the approval letter, that would be appreciated.

COMMISSIONER KISSNER: State that another way. So, the member trying to get a service.

CHAIR PARTIN: The provider is trying to get a service.

COMMISSIONER KISSNER: Like a mammogram somewhere or something. I don't know.

CHAIR PARTIN: No. The provider is trying to get a service preauthorized for the patient or a medication or a test, and the patient receives the letter authorizing it but not the provider and the patient doesn't know what the letter is.

And, so, the provider keeps on

trying to get the service authorized because they don't know that it's been approved and then----

COMMISSIONER KISSNER: My understanding is they cc in the provider.

MS. BRANHAM: It actually happens that patients and families, they're receiving denials for services that we've tried to preauthorize or performed rather than the provider.

COMMISSIONER KISSNER: There should be a cc. We've audited this and the denial letters have a cc to the provider that requested it.

MS. BRANHAM: Well, they may have a cc, but that doesn't mean they went, okay, because we're having a problem, I mean, honestly. I mean, it may say it, but----

CHAIR PARTIN: It doesn't mean we got it.

MS. BRANHAM: I just know that it creates a problem when the families present it to us and we didn't know that we could have provided the service or that the service that we had the prior authorization for had been denied. I think, Beth, that's kind of what you're relating to.

CHAIR PARTIN: Or approved.

MS. BRANHAM: Or approved, denied

or approved.

COMMISSIONER KISSNER: Okay. That's a take away. It's my understanding that confirmation of approval or denial includes a copy to the primary care. Do the MCOs want to comment on that?

AUDIENCE: The requesting provider.

COMMISSIONER KISSNER: The requesting provider, right. So, it could be a specialist.

CHAIR PARTIN: It doesn't always happen. That's why I'm bringing it up. The provider doesn't always get it, sometimes just the patient.

COMMISSIONER KISSNER: Okay.

Section 12 is all the memos written to the MACs so that they could be published on the website.

And, then, the last section, Section 13, 90% of our members are now in managed care; but of our $8 billion budget, $3 billion, so, 10% of the people left cost about $3 billion. So, we have $5 billion in managed care. We have $3 billion in fee-for-service.

And this is the Kentucky HP Performance Dashboards that they send to us. I've

worked with them to develop this communication. So, they tell us how much do they process in paper, how many do they process electronically, what's the turnaround time, what's the dollars.

So, there's two reports here. The Operational Status Report is sort of the claims engine, if you want to look at it that way. That's what we're doing to process claims on the fee-for-service paper stuff.

The second one is the Utilization Management Summary. So, this is the fee-for-service prior authorization, how many utilization management reviews do we process in a month, acute inpatient, inpatient psych, DRG, retro review, EPSDT, Impact Plus, durable medical equipment, home health, outpatient services, radiology, physician services, dental, orthodontia, hospice, nursing facility level of care, nursing facility ancillary onsite.

So, we basically break that out and show you what's going on there and how many were denied and how many were overturned and all that.

And, then, the last one is a Utilization Management - the very last report in the document - Utilization Management Operational Summary, and we basically take this and go sort of in those major

categories I just mentioned and it gives you all the breakouts. So, acute inpatient services, durable medical equipment, and we give you more detailed information like what's the top five pending reasons. You'll see that almost every time, the reason it gets appended is because it's lack of information. The provider hasn't given enough information to confirm or deny the prior authorization.

And then the top ten diagnosis codes and the top five reasons for a Medical Director denial. And, so, all of that is in there by type of service. So, you can look and find your specialty or look under a variety of things - hospice or home health or those topics. Impact Plus is in there, outpatient therapies.

So, again, one of my overarching agenda items is transparency. I've said that from the very beginning, and I think the more light we shed on stuff, the better it is for everybody.

So, these are the operational matrix reports from the other side of the house because we've been showing you operational matrix reports for the MCOs for quite some time and this is the remaining fee-for-service stuff that we've worked with HP on to develop the report.

All this is going to be published on the website as soon as we can get it there. I know you guys have requested to get the binder ahead of time. We have a problem getting that because we're doing stuff every day, every week. We could do that. It just gets kind of outdated that we're going to be discussing and posting the stuff. It would just be old. So, we'd rather give you the most current stuff that we have, but it is available, so everybody in the audience can go online and find all this information out there.

CHAIR PARTIN: The TAC reports actually are in the binder this time, but I wanted to share with you. This is one of the charts and it's from pages 8 through 31, and that's what we got for those. You can't read it. So, I just wanted to show that to you because we can't read it and that's pages 8 through 31.

MS. HOPEN: We can make a bigger copy for you. We will scan that and we'll post a bigger one on the website.

COMMISSIONER KISSNER: And that's my update.

DR. NEEL: My staff made me promise to report to you, they always read the good news' reports and they requested that you might put a

section in disaster reports, too. I brought one with me today but I won't bring it up. I think they'd find some similarities.

COMMISSIONER KISSNER: One other thing that was reported at the staff meeting on Monday was that prior to ACA expansion, we had three counties in the State of Kentucky that had less than 10% uninsured - three counties less than 10% of the population is uninsured. Today, we have 75 counties less than 10% uninsured. So, I think that's going to help everybody.

Thank you.

CHAIR PARTIN: Thank you very much. We've got a lot to read.

Next on the agenda are reports from the TACs. The first one is Behavioral Health.

DR. SCHUSTER: My eyes are blurry from trying to read the data that was sent.

Good afternoon, morning, I guess. I'm Sheila Schuster serving as the spokesperson for the TAC, and you all should have a copy of my report and I'll also email it to Barbara Epperson.

Our most recent meeting was on May 8th and we invited all five of the Medicaid MCOs and their behavioral health representatives to attend.

Three of those did attend. Coventry and WellCare were not in attendance. In addition, we had four of six TAC members and a number of people from the behavioral health community including Mental Health Coalition members.

We had asked the MCOs ahead of time to bring their pharmacy representative and/or information. We had a specific concern about access or lack of access to Abilify. Also the consumers were complaining that they were being charged as much as $400 for a prescription of Abilify.

Unfortunately, WellCare was not present and they were the MCO that was identified as the biggest offender in this regard. So, we will follow up with them directly.

Our TAC had made requests for data in July of 2013. Due to, I guess, our not understanding and the MAC not understanding how those requests for data and responses from DMS would be processed, our requests were not formally sent to DMS until January.

And yesterday afternoon via email, I received the responses. And I'm going to sit down with Erin if that's permissible and go over some of those reports because they really are not readable and we are trying to get them out to our TAC.

At this point, our next TAC meeting would be in July prior to the July MAC meeting. So, we will have been one year in trying to get some information and some questions answered which is frustrating.

We had quite a discussion at our TAC meeting about the fact that there was an open enrollment going on and nobody knew about it.

And I will say again and we've said this consistently from the behavioral health community, and this is true also from the brain injury representatives, our folks do very poorly with things that are mailed. Many of our folks think that they contain poisons or were sent from somebody who is spying on them. They don't open their mail.

The representative from the Brain Injury Alliance talked about the problems that those with acquired brain injury have in terms of attention and their ability to read and understand.

So, when the only communication goes to members, it is a significant problem I think for all members but particularly for those in the behavioral health arena.

I have created on behalf of our TAC a one-pager and I'm happy to email it to anyone that

wants to see it a very simple piece that says here's open enrollment. Here is who it affects. Here's how you do it.

We also prepared with no proprietary information but exactly the information that was sent out by mail to people to do those comparisons because as you look at those charts and tables, you understand that our folks are going to need somebody to sit down with them and make some sense of that.

Our request is that DMS immediately post on their website. We could not find anything on the DMS website announcing that there was an open enrollment period.

I think the request has already come from the Chair that providers be included, but I have to tell you, and I'm going to put on a different hat here - I'm Chair of the Board of Kentucky Voices for Health - and we have historically been at the table with DMS to help in looking at communications that would go to members to make sure they're readable and understandable and at a reading level and so forth.

And maybe that kind of help is no longer needed, but we again will offer that help. We are very active in the behavioral health community. We have very active family groups. We have case managers.

If you're going to pick providers that work with our folks, it's the case managers who ought to know what's going on and sit down with the folks and go through these things.

There's so many ways that I think this could have been done better. So, I urge DMS to post on their website. I'm happy to share with you my one-pager if you want to send that out at least to the providers by email. And I agree with Dr. Neel, that if the providers don't know, then, they don't know whether they're in those networks or not and I think it's a real concern.

We continue to be concerned about prior authorizations and outpatient therapy visits. And I appreciate and I looked at it just briefly last night the information that Lee Guice put together, but I don't see it as being very helpful - no offense, Lee.

But when you lump all behavioral health and substance abuse services and say, yes, prior auth is required, it doesn't tell you anything. Yeah, we know prior auth is going to be required on some medications and on inpatient hospitalizations and so forth; but we have very specific questions and we're getting very different answers from the different MCOs.

It is a real problem if you're

requiring a two-week-ahead-of-time prior authorization on a therapy visit for someone who is a new patient seeking psychotherapy. And that's what we're running up against, again, primarily with WellCare but I think also with some of the other MCOs.

If the outpatient services are not being approved, people are going to end up in the hospital or in jail or homeless under the bridges. That's what happens to our folks. So, I guess I would still like to figure out some way to know what each MCO is doing with regard to PA on outpatient services.

The best information I could figure out now is that they are or at least WellCare is not requiring PA if the community mental health center is doing outpatient therapy but they are requiring it for private providers. And I don't know if somebody is here from WellCare or not. Is that accurate?

AUDIENCE: I will have to check. I really don't know. Our BH person is not here, so we will check for you, Sheila, and get back to you.

DR. SCHUSTER: All right. And let me just point out that in March, we set the date so people knew when our next TAC meetings were. So, it's frustrating.

We're pleased that the MCOs are

including peer support services. We are working with the MCOs and Passport has been particularly responsive in terms of representation of consumers and family members on some of their advisory committees, and we've had some specific requests.

I will again offer in this public forum that the Mental Health Coalition is at your disposal to circulate requests for participation from then community on those committees, and I understand that that's part of what you all are supposed to be doing. So, I'm not sure how you're fulfilling that requirement.

We are concerned about the low rates and they were not responded to in the regulations; but, again, if you don't have sufficient providers and sufficient access to those low-end rates at the beginning of the process, you're going to end up with much higher costs at the end of the process.

The Brain Injury Alliance has some concerns that I'd like to share perhaps individually with the Commissioner or whoever is appropriate for that. The DCBS offices are difficult to deal with because they don't know about the ABI waiver, and, yet, that's the doorway in. So, the question is, can we have a specific worker or office that's assigned. Again,

they're concerned about the communications going to the members and not to the family members.

We had a new concern that was raised about Impact Plus which apparently is going to go out of existence as best we can tell. It's unclear to us what the service array will be for those children who have accessed those services.

I understand that the notification was just made that no new children would be enrolled in Impact Plus as of July 1st. I would really welcome some communication from the Department or from BH/DID if that's who is making these decisions.

And, again, we have asked over and over again for a Behavioral Health Ombudsman. And I saw in the letter from Erin that we're being told that we should just use the regular Ombudsman.

And, so, we will do that; but I do think that our folks have unusual and significant problems that are different than some of the other Medicaid members, and I think it would be a wise investment and a real outreach from the Department to establish somebody who can be there to talk with consumers. It's extremely frustrating when they can't get their medications and the outpatient therapy services are not available to them.

I would also say on the ADHD, I spent twenty-five years clinically doing evaluations of children for ADHD. I'm glad to see the spotlight focused on that, Dr. Langefeld. I do think it's going to take a multidisciplinary approach if you're going to look at that and drill down and so forth.

There was a legislator who was very irrate a number of years ago and tried to pass legislation to prohibit teachers from making a diagnosis of ADHD. And I say that facetiously but not facetiously.

The pressure on providers and on families coming from the school sometimes very inappropriately to get this kid on medication, to get this kid restrained, essentially chemically restrained is just wrong, and I think we need to have the education community involved in it as well.

I will tell you wearing my psychology hat that psychology would very much like to be at the table. Thank you.

CHAIR PARTIN: Thank you, Sheila. Children's Health. Consumer Rights and Client Needs. Dental.

DR. RILEY: Good morning. The Dental TAC report is in the binder under Section 11.

The TAC met on April 2nd, and it was their first meeting since September of 2013. There were a number of issues and we have some recommendations.

The first issue we discussed was the recredentialing of dentists by the state this year was a nightmare. There were reports that over 400 dentists were deactivated on March 1st. This blind-sided the providers as the majority of them had not received any prior warning and the advisory letters had not reached them.

Their first notice was that patients were unable to fill their prescriptions and their claims were being denied. When the problem came to light and the required documents were submitted, the providers were advised that DMS has sixty days after receipt of the information to get it into the system and then it updates.

Some providers were not updated until the end of April, and one provider wrote that on day 62, a letter was generated stating that he had used an outdated form and he needed to resubmit again.

Veronica Cecil from Program Integrity has been invited to the next TAC meeting. The recommendation from the TAC is that DMS consider using

CAQH for credentialing and recredentialing. That system tracks all documents and sends a timely notification whenever something expires and needs the submission of a new document.

The second issue that was discussed was communications to providers is often less than timely. The $3 copay provision that was implemented on January 1st, the notification that came to most providers was dated January 9th and the notification from the MCOs was dated 1/15 or later. By this time, numerous patients had been treated, especially with Medicaid expansion, and providers were not aware that a copay should have been collected. So, again, loss of income to providing offices.

The recommendation, any policy changes should be communicated to providers at least 60 days prior to implementation.

Number three, some MCOs have placed limitations or restrictions on EPSDT services that did not previously have them. There still has been no official notification of any policy change but it's still being enforced. Now we're told that they are working on a notification message.

Again, recommendation, any policy changes should be communicated to providers in writing

at least 60 days prior to implementation.

The fourth one, patients from some MCOs who are denied EPSDT services receive letters that contain false statements and they reflect poorly on the provider. The situation had been brought to the attention of the MCOs numerous times since November.

Our recommendation - any communication received by a patient regarding denial of services should contain only accurate statements. In addition, if the original decision is reversed, the patient should receive a letter stating that the services now are approved. They tend to not believe the provider if all they have is a denial letter.

And the fifth one is failed appointments continue to be an issue. The Dental TAC recommended at the December, 2012 meeting that DMS develop a no-show code without a charge that could be used for tracking these failed appointments to tabulate their impact on the system. It was approved at that MAC meeting.

I was informed several months later that DMS was more concerned with other pressing issues such as ACA implementation. We again bring forward this recommendation for the development of a no-charge/no-show code so that it can be tracked.

Thank you.

CHAIR PARTIN: Thank you very much. Nursing Home Care.

MR. FOLEY: No report.

CHAIR PARTIN: Thank you. Home Health.

MS. BRANHAM: Yes. We had our TAC meeting 5/5, and some questions that came up from our old business was we understand that EPSDT is medically necessary, and we had asked for a geographic pattern as far as lengths of time related to prior auths from all MCOs.

And, of course, we understand that it's related to medical necessity, but Humana stated that they would give at least eight weeks. Passport was going to do a followup. Anthem is still building their policy on that population, and we haven't received anything from WellCare but Coventry is just going to tend to take--you know, you have to call at least every month or so for a prior authorization for another month. of service.

And with the reimbursement from EPSDT, it's a lot of administrative costs related to this because there's so little change month to month for the population that we serve under the EPSDT.

We asked Pam Smith to look at our log-in on HealthNet and the ability to print. That was taken care of.

We had an open discussion on personal care related to Medicaid services while they're under a Medicare plan of care or a Medicare episode. That was my error, Commissioner, in submitting the response from Eleanor with this TAC report to say that patients that had an open plan of care under Medicare had to be covered with personal care under Medicare even if they'll lose their Medicaid card. So, they did take care of that.

We had a lot of discussion with Commissioner Anderson and the Department of Aging of the new waiver that's coming, the conflict-free case management and service provider and that most of those will probably be going--case management is probably going to be going through the Triple A's or Area Development Districts.

I understand from yesterday, we have just completed our Kentucky Home Care Annual Conference and Commissioner Anderson was kind enough to speak to us yesterday and give us a framework of what that waiver, which I'm not sure if it's been submitted or not, looks like because we've asked for a copy of

that. So, I'm not sure if it's been submitted or not been submitted or if it's in a draft form or a final form.

And I guess the one word of caution that home care providers in the state have is that the breakout for therapies to not be under the auspice of the provider but under their own ability to bill.

I know due to the ACA expansion, that it was opened up to comply with some psychologists and private duty and therapy services and the like, but we have some concern about the ability for therapists to establish somewhat their own plan of care, I suppose, even if it is under case management about the services that are needed rather than a provider that would be able to give some guidance on that and call them in as needed.

We talked a lot yesterday with Commissioner Anderson related to that and that's what some of this TAC report refers to. I think she did an excellent job yesterday in her presentation because no communication sometimes leads to miscommunication. So, the different groups of folks that she had met with were formulating their own thoughts and pleasures, and I think she lined that out very adequately yesterday.

Home health did know it was open enrollment - I'm sorry, you all - because we had discussion at our TAC meeting that related to if we had just received prior authorization under an MCO say that week and then we were notified in some form or fashion that the client was moving to another MCO, would they honor that at least for the first several visits or what-have-you.

Reports back to that. Passport will, and I think everybody gave it some consideration, of course, knowing that as soon as we did those one or two visits or whatever that auth was for, that we would know that we would have to contact them.

The private duty expansion under ACA has not gone as smoothly as we had hoped, Neville. And we have been working with Stewart and Lee and folks to try to find where this should be submitted but nobody knew about it. Again, no communication creates miscommunication.

And if we're trying to get approval to enter people into these programs and even at the Medicaid level nobody knows what to do with any type of assessment or anything like that, then, it does create a problem for it. And, again, communication is the key to take care of clients that are in a

requirement for services.

As of Monday, I'm really just not sure if those--did they get it, Lee?

MR. GUICE: It's taken care of.

MS. BRANHAM: Well, I have everything you've been sending. So, that's really adequate for us to cipher on out to the home health community.

Still some discussion - and maybe you all can tell me so I can communicate - about home health agencies are able to provide private duty for where they have a certificate of need. They do not need a private duty license.

MS. GUICE: Correct.

MS. BRANHAM: And if you have a private duty license, you can provide that same service under that license as well.

MS. GUICE: Correct.

MS. BRANHAM: And if you have a provider number for Medicaid, then, you bill under that private duty or you bill under the home health or do we all need to get new provider numbers?

MR. WISE: Yes. It's a new category.

MS. BRANHAM: So, we have to get provide numbers for both home health or private duty agencies, depending on which one you're going to provide that service under for this ACA expansion.

MR. WISE: Correct.

MS. BRANHAM: Okay. Got it. I'm not sure, Lee, about some kind of special form you all are working on. Pam was talking about finalize a form by the end of last week.

MS. GUICE: It's the criteria for the prior approval. It's on the website.

MR. BRANHAM: Okay. We're waiting on an updated list with the new MCOs that are coming in for the MCO liaison assignments from the Cabinet so that can be disseminated.

Again, we talk a little bit about the letters of approval or denial for services make it difficult when it just goes to the family and not the provider.

The DCBS office, we have difficulty getting clients through that front door on waiver services, and we all know we have lots of slots in the waiver services, and getting them to start on-- the 551 is difficult. So, we need to work some way, working for now but looking forward to the future for

keeping people out of long-term care that don't need to be there. When they come out of institutional care or skilled care, that we can get quick approval when all paperwork has been completed rather than living a message on the 1/800 number asking for somebody to call us back. We have folks that have been hanging around on that line for a couple of months trying to get their approval. So, this is something that we need to be proactive about for future and then active about for current situations.

We've had difficulty with Coventry on denial of services with prior authorizations and services being delivered because their prior authorizations have been loaded inaccurately.

I know that we always talk that through the TACs is where we try to resolve our issues that we bring to the MAC. And I want to give a shout out to the MCOs that came to meet with providers at the Kentucky Home Care Association speed dating roundtable discussions that we had yesterday. Everybody came except Coventry.

MS. HATCHETT: Because we have a separate meeting scheduled with you on June 3rd.

MS. BRANHAM: That's a call.

MS. HATCHETT: It still is the

forum.

MS. BRANHAM: Well, that's a call.

And there were folks there yesterday that were ready to have some discussions and try to get some issues resolved.

And we do have a call scheduled on June 3rd; but at the TAC meeting on 5/5, there was a discussion that our annual conference is going to be held conveniently located at the Marriott and everybody asked to come and we said we would set something up because you had a great forum to have discussion one on one and work through issues.

It was a great environment to try to get some of those things conducted; and on Monday, we found out Coventry wasn't coming. We do have a call on the 3rd, but with providers from all hundred agencies on the call, that may be a little bit more difficult to manage one-on-one situations as if we could have done it face to face.

Just realizing that we have been going at this since November 11th and we've worked through lots of issues; and when we say we need you there, that's because we need you there to discuss issues. That's our forum to do it.

Now, I will say in this open forum that if we don't get issues resolved on our June 3rd call, then, I would look to Coventry to have to do a followup when we're gathered again just so that we can keep the lines of communication open.

And I guess that we looked at the Governor's healthcare plan or issues, and one of those are re-admissions and you look at it, whether it's newborns and mothers that are going home. One time I'll say that home health is not used and that's with newborns and deliveries that have had issues that are relating to that, and that may be something that the case managers of the MCOs may be focusing a little bit on about maybe trying to integrate home health a little more into that.

Now I'm open for questions if anybody has any.

MS. HATCHETT: I'm Jennifer Hatchett from Coventry. I just wanted to say that we had communicated in advance that we weren't going to be able to be present. Holly Garcia had communicated with you.

But on the pediatric, we totally agree with that, and what we're having issues with newborns coming home is that there actually is a need.

We're just not finding agencies who have pediatric abilities, especially in Eastern Kentucky.

So, we are willing to partner with anyone to be able to develop some of those services because we do find a huge need for newborns who are being discharged from NICU to have those home health services, but finding pediatric specialists has been very difficult.

MS. BRANHAM: I have one more.

CHAIR PARTIN: We're getting short on time.

MS. BRANHAM: I'd like to introduce to the room at large, our Managing Director is able to be here today with us from North Carolina, South Carolina, Kentucky because he was up for the conference. Just wave your hand. This is Tim Rogers that's here with me today. Thank you.

CHAIR PARTIN: Thank you. And I would like to ask, we've got several other reports and a couple of items on the agenda and we've got about fifteen minutes left. So, the Hospital TAC is next.

MR. MILLER: Good afternoon now. My name is Steve Miller with the Kentucky Hospital Association. I'm filling in for Carl Herde who is Chair of the Hospital TAC. You have as part of the record the

minutes from our May 6th meeting.

What I'd like to do today is take a few minutes and go over some of the regulations, three specifically that we have brought before the committee in the past and give you what the current status is of those three.

The first one was the behavioral health. We want to thank the Cabinet for amending the regulation to allow hospitals to provide that service on an outpatient basis. We think that is a major step in the right direction. It now allows the Medicaid recipients who we have heard earlier in today's presentations that are in desperate need of those type of services. We believe it gives them better access to that.

The second regulation is the DRG regulation, and right now it's being deferred on a month-to-month basis. You may recall that the primary concern of the Cabinet was to address the needs surrounding the implementation of ICD-10 that was going to come on board on October 1st of 2014. Congress has now delayed that for another year.

Hopefully, this will give additional time for the Cabinet and the hospitals to address the issues that we've had with the new

regulation itself. Hopefully the time will be given to that.

The third regulation is cost sharing which has been discussed already this morning, and, candidly, we and the Cabinet are far apart on this one. Operationally, we have not figured out how to implement that within the hospitals' operations. We have not been able to reconcile the federal requirement, the state regulation and the SPA that was approved by CMS.

We believe that the federal regulation requires that the attending professional at the ED make the determination if the required care is emergent or non-emergent and inform the patient then. That is also what the SPA that was approved by CMS say.

The MCOs in many cases are denying delivery of that service after the fact based upon what is on the claim. Obviously when that is changed at that time, we are not able to inform the patient after the fact nor collect the $8. And it's not our concern right now about the $8. It's how we follow the regulations.

On May 13th, the Administrative Regulation Review Subcommittee reviewed that regulation. You may know or may not know that they found it to be deficient and attached a letter stating so. It was

point blank asked then if the Cabinet would be willing to defer it an additional month and they said no. Hopefully we can work out the differences but we see them as being vast right now.

I'm happy to entertain any questions.

CHAIR PARTIN: Thank you. Next we have the Optometric TAC.

DR. WATKINS: We're happy to report that we did successfully have a meeting with the Commissioner, several of our officers and ourselves to make amendments to the prior regs that were released and we have reinstated the per provider per year exams so that we have the ability to have covered referrals and second opinions.

We had several codes added in that had been omitted from the previous regs. So, things have come to a good end there for us and we have been able to make those amends.

I also want to send out kudos to EyeQuest on behalf of Anthem. I did receive a first visit yesterday from them as a provider just seeking out different providers throughout our area, letting us know the website and giving us their cards and just making sure their concerns were out there, that they were able

to communicate with us, and hopefully that will be a sign to the other MCOs to follow suit. Thank you.

CHAIR PARTIN: Thank you. Therapy Services.

MS. ENNIS: I'll be quick. I'm Beth Ennis. I'm the Chair of the Therapy TAC.

We did meet again this morning and you don't have any of our minutes yet because they're still in revision from this morning as well as our previous two meetings.

However, the only things I did want to bring up were a question on did the OT hospital-based restriction get removed. We had asked about that I believe at the last meeting and hadn't heard anything back about that or the therapy differential and how that was going to be applied in different settings.

There are different rates for therapists versus assistants but things get billed under either a facility code or the therapist's number and people are concerned about billing fraudulently because there's no way to say this was the PTA or the OT assistant versus the therapist.

The third question that came up was there appears with our Medicaid fee-for-service, especially children, that there's a 30-day re-cert in

place for those original twenty visits that were just put in as part of the new benefit. And our understanding was once those were prior-authed as medically necessary, there shouldn't be a re-cert for those twenty visits; but they're being told that there is, and by the time they get it, 30 days are up and they're having to re-cert again. So, we had a question to the Cabinet about that.

And, then, there's still an issue with our children on waiver. We're asking that a work group be assigned to look at that process because sometimes it appears that during the re-cert process for waiver, things aren't getting in in a timely manner and the child is being kicked to an MCO which then denies services because the child should be on fee-for-service and going through the waiver program and that's affecting services and equipment both.

And sometimes it may just be something in the MMIS system that's kicking them over to an MCO versus staying in fee-for-service and it's impacting how they're being treated.

I did email all of those originally to Sharley but I did forward them to Barbara at the beginning of the meeting. So, she should have those.

CHAIR PARTIN: It sounds like you have----

MS. ENNIS: Three new questions and followup on an old one.

CHAIR PARTIN: The first one was a followup on an old one, correct?

MS. ENNIS: Correct.

CHAIR PARTIN: Can anybody answer that for her?

MS. ENNIS: Has the OT in the hospital-based services' restriction been removed or is that still in the process?

MR. DOUGLASS: It has been.

MS. ENNIS: It has been. Thank you. I can take that back to them, and then the other three were new. Thank you very much.

Physician Services.

DR. NEEL: No report.

CHAIR PARTIN: Podiatry. Primary Care.

MR. BOLT: Good afternoon. David Bolt with the Kentucky Primary Care Association. The only bad news I've got is that my wife sent me a text that our water heater exploded. So, I'll be short and sweet.

We have three recommendations and one thing to report on. We have established routine meetings. The schedule will be July 10th, September 11th and November 6th. And as long as the Commissioner will graciously allow us to use his conference room, that will be where the meetings are held.

Three specific recommendations. Number one, we would ask that DMS develop and expedite a process for the payment of claims for dual eligibles. This has been under discussion for some time and just wanted to bring it up here as we mentioned we would at the last meeting.

The second request is that DMS expedite the process for finalizing interim rates. We have over 41 clinic sites whose final rate-setting process has been going through the reviews for well over a year. And that may create a situation where they either owe money back or they are owed money. So, it works out to the benefit of DMS and the provider as well.

The final item is we would like to request that DMS look at same-day billing for physical health, behavioral health and oral health services which would bring in line the regulations of the state with CMS final proposed PPS regs at least for physical health

and behavioral health services.

It also brings into play the question about the conflict between DMS regulations and the standard of care limiting non-emergency dental visits to I believe one a month. We think moving that to the standard of care may well prevent downstream costs and prevent ER use for oral health patients.

Thank you all for your time and I hope everybody else is short, too.

CHAIR PARTIN: On one of those points, I have a question to DMS. Is there not a time limit for you all getting those final rates set? Can you take years to do that?

COMMISSIONER KISSNER: Yes.

CHAIR PARTIN: That doesn't sound reasonable.

COMMISSIONER KISSNER: But you've got to understand the process which was not described there.

The provider submits a cost report and says here's my cost of doing business. Here's what I'm spending. That gets reviewed; in a timely fashion, gets reviewed and gets submitted and an interim rate is established. They have to get through a 12-month period, a full fiscal year.

So, let's assume their fiscal year was the same as the State fiscal year and it was 7/1 to 6/30. For January 1st, they said here's what I'm spending money on and we establish their interim rate.

You would go to the next year, to 7/1 of that next year, and you'd say, okay, so, then, 7/1 of the next year, we'd have the first twelve months under the interim rate. So, now we're eighteen months past setting the interim rate. We're eighteen months down the road and we say, okay, you get to--they have to submit it to us. So, we wait on them to submit their report.

There's nothing that says the very next month, you know, August of the next year, they have it ready to go. It takes two or three or four months to get their quarterly end report and they say, okay, here's my first full fiscal year of costs.

We then take that, run it through. It takes us about ninety days. We operate within ninety days and we take it and say here's the final rate. Then they have a dispute resolution process. And I would say 95% of the time if the rate is going down from interim to final, they say I don't like it, I want to dispute it.

And, then, you get to the

administrative hearing and then you're on their clock and they can take as long as two lawyers agreeing to postpone and postpone and postpone and we're then waiting for the final resolution of that final rate.

So, we're easily two years, easily two years in what I just described down the road until we say, okay, here's your final rate. And the final rate goes back to the beginning of time and we then have to do a reconciliation which takes another potentially ninety days to do the reconciliation to say, okay, here's the final rate.

Many of those processes are out of our control. That's what I want you to understand. So, we don't submit a cost report. They submit a cost report to us. That's how they get their interim rate, and then they have to submit. So, some don't submit the next full year. And if they drag their feet because they've realized their cost went down - I don't control that - we keep paying the interim rate until they submit a report.

So, yeah, I mean, we operate in 90-day time frames from when reports are submitted, but it is required by CMS laws that you get a full fiscal year. So, anybody that starts in an off fiscal year, you immediately get a year plus whatever that off cycle

was.

MR. BOLT: Counterpoint. I don't disagree that that is the process; but what we were reporting, the 41 are those who have submitted a cost report, and that review process at DMS has taken longer than a year.

I didn't mention that ten of the organizations that have not submitted cost reports, shame on them. That's their problem. What we're trying to resolve is the issue with those who have completed the process. They've gone through the interim rate. They've gone through the rate-setting year and they have submitted an audited cost report, and those were figures given to us by DMS staff.

CHAIR PARTIN: So, it shouldn't take--if there's no arbitration and the person has submitted their reports on time, then, it shouldn't be longer than a year. Is that right?

COMMISSIONER KISSNER: I believe that somewhere in there, we're talking FQHC's and rural health centers, right?

MR. BOLT: Yes, sir.

COMMISSIONER KISSNER: So, we have to submit it to CMS?

MR. BOLT: No.

COMMISSIONER KISSNER: There's no process where they are involved at all?

MR. BOLT: No.

COMMISSIONER KISSNER: Okay. We'll get a status update on where we are on that, on the 41, but the ten----

MR. BOLT: That's their problem.

COMMISSIONER KISSNER: Well, it's everybody's problem because we're probably paying-- there's a reason why they're not submitting. It's either they don't have their act together which is embarrassing on theirs, or they realized my costs are going down and I don't want to submit a report because as soon as it goes down, I'm going to get dinged. So, that's not good business.

And that's something that in a transparency mode, it's both sides of the equation should be transparent and that's one where we should list the ten and say, come on, guys, get it in. You need to send us something and we want that.

MR. BOLT: And as we have done in the past, if we get a list of who those ten are, we'll make some personal visits.

COMMISSIONER KISSNER: Okay, and we'll do that as well.

CHAIR PARTIN: So, I guess I'm just asking that for those people who follow all the rules, that DMS be timely as well.

Intellectual and Developmental Disabilities. No report.

We are just a little bit over time but we've got just two other items that I wanted to include. One of them has been touched on and that is with WellCare. And do we have a WellCare rep here still?

MR. RIDENOUR: Is that the preauthorization question?

CHAIR PARTIN: Yes, for the psych/ mental health. I have some information here about the patients are not required to have a referral but they're required - and they rarely bring a card to an appointment - but they have to have fourteen days-- WellCare is asking for fourteen days in order to approve that visit.

So, what about the problems when a patient needs to be seen and the time span is shorter than fourteen days?

MR. RIDENOUR: Thanks, Madam Chairman, members of the committee. I'm Mike Ridenour with WellCare Health Plans. Lori Borden is our Director

of Behavioral Health. She is not with us today, so, I know just enough to be dangerous.

But what I do know is that the 14-day preauthorization requirement is for what you would consider to be routine outpatient types of therapy services. And even that requirement is not a hard-and-fast. If a preauthorization request is submitted on day ten before, it's not automatically disapproved.

The issue you have is that the 14-day window that's offered to providers----

MS. RUSSELL: My name is Pat Russell. I'm with WellCare as well. Mike is a bit dangerous. Our authorization requirements do say fourteen days. You left out a key word. It should say within fourteen days. So, anytime between two days and fourteen days where you can call for authorization.

MR. RIDENOUR: Right. The minimum time is two business days to turn one around.

MS. RUSSELL: And that's simply because of the time it takes us to get the information back.

CHAIR PARTIN: So, there isn't a wait of fourteen days?

MS. RUSSELL: No, ma'am.

MR. RIDENOUR: But every day that

you wait, you know, in a perfect world, it takes two business days. So, that's why we suggest the fourteen. It's basically a safe harbor for both the provider and the member if they can do it.

MS. RUSSELL: But the document should say within fourteen days.

CHAIR PARTIN: This is not a new policy but the providers were not notified about the policy.

MS. RUSSELL: Well, I think we did make some changes to authorization in other areas, and we updated our grid and we forgot to put the within fourteen days on the BH is my understanding, but we're putting out new documents to clarify that.

CHAIR PARTIN: You're going to send that to all the behavioral health providers so that they have that information?

MS. RUSSELL: We'll make sure that communication gets out to all of them, yes.

CHAIR PARTIN: And then I would ask in the future that if there's changes made, that the providers are notified so that they're not out there trying to figure out what's going on.

MS. RUSSELL: Absolutely.

MR. RIDENOUR: For crisis

stabilization, there is no preauthorization unless a facility, for example, intends to keep them longer than five days. I think it's inpatient acute, there is no preauthorization required, but we do require notification within 24 hours of admission.

And if it's inpatient subacute, it's the same thing - no preauthorization required but we do require you to notify us within forty-eight hours of admission. So, really, it only applies to those what you would call routine therapy visits is the 14-day requirement.

CHAI9R PARTIN: And how would the provider know? If a patient has been placed on their schedule, how do they know that they have to get that preauthorization because they don't even know what kind of insurance the patient has beforehand?

MR. RIDENOUR: It should be pretty uniform across the plans, I would think.

MS. RUSSELL: I would think most all the plans are pretty similar in those areas. I really don't know. The best thing to do is to determine which plan or try to. I know the member never bring a card but----

CHAIR PARTIN: Right. They don't bring a card----

MS. RUSSELL: You could always go on the KentuckyNet site and see who they have been assigned to on the eligibility side.

CHAIR PARTIN: Behavioral health isn't my field. So, I'm asking these questions because the issue has been brought to me, but as a provider, if somebody is on my schedule and I don't know what they're coming for, how do I get that preauthorized?

If I had to have a preauthorization for a sore throat and the patient was on my schedule, I wouldn't know how to preauthorize it because I wouldn't know what was wrong with them until I saw them.

MR. RIDENOUR: Don't all outpatient therapy services require a preauthorization?

MS. RUSSELL: I'm not sure, Mike. I'd have to check.

MR. RIDENOUR: That's where we need our PRO.

CHAIR PARTIN: If you could come back and provide us some information on that, but I just don't understand how they're going to get the visit preauthorized when they don't know what the visit is until after they see the patient.

MR. RIDENOUR: We need to verify

that, but that's my suspicion is that it would be routine.

COMMISSIONER KISSNER: Just to be clear because there was some confusion last time from Anthem about responding. So, if you submit to us the formal questions for each MCO, we'll pass them along and get something back in writing from them.

So, that would be if the MAC wants to ask questions of the MCOs and get a formal, because even though we're on the record here and everything, I think it would be better for them to, rather than saying I'm not really sure exactly what the requirements on, they could come back and give you a researched answer which would be better.

If you want to ask the question of multiple MCOs, then, just say we want all MCOs to answer the following question and then send it to us and we'll distribute it to them and follow up and make sure you get it.

CHAIR PARTIN: So, I should send it to Barbara?

COMMISSIONER KISSNER: Yes.

CHAIR PARTIN: We'll do that. Thank you very much.

The last thing I wanted to bring

up was just of the committee. The response to the behavioral health, there was a recommendation that the committee look at the Deloitte Study and review it and have some discussion about it. And, so, I would ask all of you to look at that and then at our next meeting come back so we can discuss that report and any issues related to that.

That's all I have. Does anybody else have anything else? Thank you very much.

MEETING ADJOURNED